| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175418 | A. BUILDING _____ B. WING _____ | 10/31/2012 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS59537, #KS60173, #KS59180. | F 000 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 73 residents, based on observation, staff interview, and record review, the facility failed to provide housekeeping, and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>Findings included:<br><br>- An environmental tour of the facility at 2:00 PM on 10/24/2012, with maintenance staff W revealed the following:<br><br>Lobby/dining area:<br>* The walls with multiple stain and various sized chips in the paint.<br>* The doors to the outside patio, soiled, with paint chipped and missing in various areas, on the metal door and frame.<br>* Two bug zappers on the wall, near exit doors, with multiple dead bugs. Maintenance staff W stated, " They are cleaned monthly, but not yet | F 253 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 253 | Continued From page 1 | F 253 | | |

this month. They need to be cleaned. "
* Three worn rugs on the floor at the entrance/exit doors, rubber edges to all sides of the mat torn and missing.

South hallway:
* Numerous resident rooms had nail holes, soiled, scuffed, and stained areas on the walls.
* Most resident bedroom and bathroom doors and door frames were scuffed, scratched, and soiled.
* The south nurse's station floor had chipped flooring and were soiled and stained.
* The women's shower room had an unpleasant musty odor. The floor in the shower stall room was soiled with black build-up along the sides of the walls. A light bulb above the sink and mirror lacked a cover. The ceiling vent in the bathroom had visible white build-up on the vent.

North hallway:
* Most resident rooms had nail holes, soiled, scuffed, and stained areas on the walls.
* Multiple resident bedroom and bathroom doors and door frames were scuffed, scratched, and soiled.
* Two shower rooms had missing/stained caulking around the toilets. Base boards in both shower rooms loose/missing.

Interview with maintenance staff W at 2:00 PM on 10/24/2012, revealed, " This is an old building, built in the 1960's. I try to keep up with it, but it's hard. I just painted the doorways in the main lobby two months ago and the paint is already dirty, chipped, and missing. I have a facility maintenance list, but there is so much to do, that it is not up to date and I have not filled it out for a

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| F 253 | Continued From page 2<br>long time. Usually when something needs repaired the staff calls me to fix it. "<br><br>The facility failed to provide housekeeping and maintenance services to maintain the facility in a sanitary, orderly, and comfortable manner. | F 253 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 73 residents. The sample included 21 residents. Based on observation, record review, staff and resident interview, the facility failed to provide the necessary treatment and services to attain or maintain the highest practical physical, mental, and psychosocial well-being for 1 (# 38) of two residents reviewed with open areas.<br><br>Findings included:<br><br>- The annual Minimum Data Set (MDS) for resident #38, dated 2/16/2012, documented the resident had intact cognitive status, and was independent with ADLs (Activities of Daily Living), with skin intact and was a low risk for pressure ulcers. | F 309 | | |

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The care plan, dated 10/10/2012, revealed the resident with a history of reoccurring open areas to lower extremities and reoccurring cellulitis (a skin infection caused by bacteria). The resident picked at his/her skin, often refused bathing/showers, or to change their clothes. The staff would administer treatments per physician orders.

Review of the TAR (Treatment Administration Record) for October 2012, revealed a treatment dated 10/11/2012, "Cleanse left shin with Karcleanz, apply PolyMem, secure with tape and change daily." The treatment was circled on 10/12/12 and 10/13/12 which indicated the treatment was not done and noted that the treatment was "Dc' d [discontinued] out of PolyMem." Further review of the TAR revealed the order was crossed out with "Never ordered" written on the form.

Further review of the October 2012 TAR revealed the following orders: 10/18/2012 "Cleanse left shin with Karaclenz, Santyl to yellow tissue, moist 2 x 2 ( 2 inches by 2 inch) cover with 4 x 4 ( four inch by four inch) gauze and tape. No COBAN."

10/23/2012, "Cleanse open area on right foot with wound cleanser, cover with non-adherent pad and secure with tape, change daily."

Review of a physician telephone order dated 10/12/12 stated " Wounds on inner left lower leg and great second and third toe, wet to dry dressing, and change once daily and prn [as necessary] to wounds ". The physician phone order revealed "VOID" written over the order, the

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| F 309 | Continued From page 4<br>order was signed by licensed nurse H and with no signature from the physician.<br><br>Review of the clinical record revealed a nurse's note dated 10/13/0212, at 3:15 PM, which indicated staff removed the dressing, wound with increasing foul odor, and the wound had purulent brown and yellow drainage on the PolyMem. The note said the facility failed to have PolyMem dressing so staff applied wet to dry gauze, and secured with Coban without a physician order. The skin around the wound was white and macerated, would contact the physician about changes in the wound.<br><br>Review of the clinical record revealed a nurse's note (untimed) dated 10/20/2012, said consultant staff X assessed the resident on 10/18/2012. The late entry nurse's note indicated staff treatment of the resident's left leg with wet to dry dressing was not ordered by the physician or consultant X. The noted said the resident had Coban wrap to the left lower leg which included his/her toes. This wrap caused a deep indentation into the tissue just below the resident's knee. Removal of the wrap from the resident's toes revealed a wet gauze between the toes, two toes each with an open area which were were discolored and cool to the touch. Most of the wound bed had necrotic tissue. Staff started a wet to dry dressing with a debriding agent.<br><br>An observation on 10/24/12 at 10:40 A.M. revealed the resident finished bathing and sat on the shower chair. The resident's lower right extremity from the knee to the foot had slight | F 309 | | |

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edema. The skin from the knee to the foot was wrinkled, shiny and reddish in color. An open area on the shin measured 6.5 cm(centimeters) by 2.5 cm per licensed nurse H, approximately 4 cm below the open area was an intact blister. The first three toes of the right foot were grayish/blue in color. The right great toe had white wrinkled skin across the top, around to the middle and the bottom of the toe. An open area to the great right toe measured 2 cm round per licensed nurse H measurements. The third toe on the right foot had a round white area that licensed nurse H stated was an intact blister.

During this observation on 10/24/12 at 10:40 A.M., licensed nursing staff H provided wound care to the resident's wounds. Licensed nursing staff H entered the shower room and looked at the resident's wound's, removed a retractable tape measure from his/her uniform pocket, placed the tape measure directly on the open wounds, measured the open wound's on the resident's foot and shin. The nurse then retracted the tape measure and replaced back in into the staff's uniform pocket. Staff H left the shower room, and returned with the treatment cart and placed it in the doorway of the bathroom. Staff H failed to wash his/her hands upon returning to the shower room. He/she removed the retractable tape measure from his/her pocket a second time and measured the open wounds to the resident's right toes and right calf. Licensed staff H removed a pair of scissors and an ink pen from his/her uniform pocket and placed them directly on top of the treatment cart. The staff failed to wash his/her hands, applied a pair of gloves, opened the drawers to the treatment cart removed a wound cleanser, 4 inch by 4 inch

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gauze sponges, Telfa non-adhesive pads, and placed the items directly on top of the treatment cart without a barrier between the wound supplies and the surface of the cart. Staff H then opened a Telfa non-adhesive pad and placed it directly on the top surface of the cart. The staff sprayed the resident's toes from the bottle of wound cleanser and cleansed the toes and areas between the toes. He/she removed the dressing which revealed serosanguinous (blood and fluid) on the dressing, and placed it on top of the treatment cart. Staff picked up the Telfa pads, placed them on the open wound on the right great toe, and secured it with Mefix. Licensed staff H then cleansed the open area to the right shin. He/she moistened 2 inch by 2 inch gauze with wound cleanser, rolled them into balls and placed them on the open wound, covered the area with gauze and secured with Mefix.

On 10/24/2012 at approximately 10:50 A.M. an interview with the resident indicated he/she was unsure how the open areas on the legs and feet developed. He/she said it hurt when he/she walked with shoes on. The resident said he/she would wear slippers if he/she had any.

An interview with licensed nursing staff H on 10/24/12 at 10:55 A.M. revealed the open areas were improved and was unsure why some of the area was macerated, and was unsure when the blisters on the toes developed. Licensed nursing staff H said the the treatment for the shin started on 10/10/12 and there was no documentation when the blisters developed to the toes. He/she said he/she usually did the resident's treatment in his/her room, and took the supplies into the

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| F 309 | Continued From page 7<br>resident's room.<br><br>An interview on 10/25/12 at 9:50 A.M. with administrative nurse D revealed he/she expected the staff to follow standard precautions, expected them to keep things as clean as possible, and wash hands between cares. He/she said he/she did not expect them to bring the treatment cart into the shower room but to take the necessary supplies into the room.<br><br>An interview on 10/25/2012 at 11:40 A.M. with consultant staff X revealed the resident was non-compliant, and would not let staff look at the open areas. He/she said that he/she attempted numerous times to have the resident removed his/her shoes and wear something that would cause less pressure to the area, but the resident refused. He/she started the resident on Bactrim DS twice daily for ten days for cellulitis, attempted to look at the resident's leg/toes on 10/15/12 but the resident refused. He/she ordered a wound consult and started the resident on Cipro 250 milligrams (mg) for 5 days. Consultant X said he/she did not feel the nurse did any harm to the resident with the wet to dry dressings and would write an order to cover it.<br><br>An interview on 10/25/12 at 12:50 P.M. with administrative nursing staff D said he/she was not aware of the late entry in the nurse's notes or the change of treatment by the nurse until 10/24/12. He/she said the hospital notified the facility that the resident was admitted to the hospital on 10/24/12 for wounds. | F 309 | | |

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| F 309 | Continued From page 8<br><br>The facility provided wound care policy and procedure dated 6/11/2008 said the facility would provide a quality wound care program which promoted healing, prevented infection, managed existing pressure ulcers, prevented development of pressure ulcers (unless unavoidable) and prevention of new sores. Furthermore, the policy stated, "Changes in wound, refusal of a treatment, anything unusual, or pertinent information will be documented. This includes a total description of all decubiti, including depth, stage, and drainage on a weekly basis and at any time a change is noted."<br><br>The facility failed to ensure this resident received necessary treatment and services to prevent and promote healing of the open areas to his/her right lower extremity. | F 309 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 73 residents. The sample included 21 residents. Based on | F 371 | | |

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| F 371 | Continued From page 9 | F 371 | | |

observation and interview the facility failed to prepare food under sanitary conditions on 2 of 4, and failed to distribute, serve and maintain a sanitary dining environment for 1 or 2 dining room on 1 of 4 days on site of the survey.

Findings included:

- On 10/25/12 at 11:00 AM, during the kitchen tour, observation revealed the following:

1) Dry storage room racks holding dry goods had visible brown grime on them and the floor with visible dirt.

2) The dry storage room floor had visible dirt on it and the baseboards had a brown substance on them.

3) Two double door refrigerators with visible brown substance on the outside.

4) Four door freezer with a visible brown substance and a brown greasy substance on the outside.

5) Hallway to the dry storage room had missing baseboard and an approximate 2 inch by 6 inch pieces of dry wall.

6) Clean dishes stored on four wheel carts with visible brown grime on the outside of the carts.

7) Clean pots and pans stored on shelves with torn shelf paper with visible brown substance on it

8) Food processor with visible brown grease and

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| F 371 | Continued From page 10<br>grime on the outside,.<br><br>9) Ceiling above the microwave with two missing pieces approximately 10 inches in diameter.<br><br>10) Ceiling in the hallway to the dry storage room with black grime on the vent and black spots in various places of the ceiling, and pieces of plaster missing from the ceiling corners approximately 4 inch x 4 inch in size.<br><br>11) No air gap between the drainage pipe from the ice machine and the pipe it drained into.<br><br>12) Ice machine with visible brown substance on the outside and on the metal vents.<br><br>On 10/22/12 at 11:30 AM, observation revealed several residents ate with plastic cutlery and all residents who had salads received the salad in Styrofoam bowls.<br><br>Observation revealed on 10/22/12 from 11:40 A.M. to 12:00 P.M. staff served and removed trays for the residents. Staff served and cleaned up after eating for the resident's in the downstairs south dining area, but the residents cleaned up after eating by removing their utensils and plates from the trays and disposed of them.<br><br>On 10/25/12 at 12:10 PM, Dietary Staff R stated the facility failed to develop a deep cleaning schedule for the kitchen.<br><br>On 10/25/12 at 12:30 PM, Dietary Staff R stated the residents cleaned their own trays and sometimes threw away the bowls, plates and silverware. | F 371 | | |

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| F 371 | Continued From page 11<br><br>On 10/25/12 at 3:36 PM, Dietary Staff R verified the staff did not develop a cleaning schedule for the ice machine and staff never emptied and cleaned the inside of the ice machine. Dietary Staff R verified all of the above findings in the kitchen.<br><br>The facility failed to prepare, distribute, and serve food under sanitary conditions for the residents.<br><br>- " During an observation on 10/22/12 at 11:44 A.M. dietary staff S served fajitas to residents in the south dining area. With gloved hands, Staff C touched surfaces of the steam serving table and sour cream packages. Without changing the contaminated gloves, Staff C then touched tortillas with the contaminated gloves.<br>During an interview on 10/22/12 at 12:10 P.M. dietary staff S reported he/she did not realize he/she had touched so many items while wearing the same gloves but agreed he/she did not change gloves before handling the food.<br>During an interview on 10/25/12 at 4:09 P.M. dietary staff R reported staff should wash hands and change gloves between touching nonfood surfaces and food.<br>The facility's south Dining Serving Policy dated September 14, 2011 included, " All condiments fresh or packaged shall be handed out to each individual resident in front of them, not tossed or slung; wash hands and put gloves on, they shall be worn to serve prepared food with utensils. If for any reason you touch any other item such as bread sacks, lids on steam table, clothes, your | F 371 | | |

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| F 371 | Continued From page 12<br>body, please stop, wash your hands and change your gloves. Nothing shall be touched except plates and utensils with gloves on " .<br>The facility failed to serve food in a sanitary environment in the south dining area. | F 371 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 73 residents. Based on observation, interview and record review, the facility failed to accurately and safely provide pharmaceutical services to 1(#21) of the 10 residents sampled for medication usage. | F 425 | | |

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| | 175418 | A. BUILDING _____ B. WING _____ | 10/31/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PROVIDENCE LIVING CENTER | 1112 SE REPUBLICAN TOPEKA, KS 66607 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 425 | Continued From page 13 | F 425 | | |

Findings included:

- Resident #21's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 8/2/12, indicated the resident has a (BIMS) Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS further indicated the resident was independent with bed mobility, transfer, walking in room, locomotion on and off the unit, and eating. The resident received antipsychotic, antidepressant, antibiotic and diuretic medications.

The 8/16/12 care plan directed the staff to administer medications to the resident as ordered by the physician and to notify the physician if the resident exhibited any side effects.

Review of the August 2012 Medication Regimen Review sheet from the pharmacist indicated to the physician to discontinue the Erythromycin (an antibiotic) originally started on 8/22/12.

The September 2012 (MAR) Medication Administration Record directed the staff to administer only Erythromycin 250 (mg) milligrams, one half tab, by mouth, twice a day.

Review of the 9/17/12 physician's office visit form revealed directions from the physician to continue administering Erythromycin 125 mg (1) tablet, twice a day to the resident.

The 9/28/12 Physician's orders directed the staff to administer to the resident the following: 1) Erythromycin (an antibiotic) 250 (mg) milligram, one half tablet, (125 mg) orally, twice a day (the medication started on 9/18/12).

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| F 425 | Continued From page 14 | F 425 | | |

Review of the October 2012 (MAR) Medication Administration Record revealed staff administered the following to the resident:

Erythromycin 250 mg. one half tablet (125 mg) by mouth twice daily from 10/1/12 through 10/8/12. The MAR revealed staff administered the medication to the resident for 8 days in October then stopped, The MAR revealed the order was highlighted and crossed out with "Duplicate Order" written on the medication.

The next line on the October 2012 MAR directed the staff to administer to the resident:

Erythrocin Stear Filmtab, 250 mg, one half tablet (125 mg) by mouth, twice daily for gastrointestinal (GI) upset. The MAR revealed staff documented they administered the medication to the resident twice daily from 10/1/12 to current date of 10/25/12.

On 10/24/12 at 11:15 AM, the medication aide administered medications to the resident.

On 10/25/12 at 2:15 PM, Nurse D verified staff administered a double dose of the antibiotic medication to the resident for 8 days in October 2012.

Review of the Policy and Procedure for the Management of Duplicate Medication Therapy indicated duplicate therapy was generally not indicated, unless current clinical standards of practice and documented clinical rationale confirmed the benefits of multiple medications from the same class or with similar therapeutic

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| F 425 | Continued From page 15<br>effects.<br><br>The facility failed to accurately and safely provide pharmaceutical services for this resident. | F 425 | | |
| F 463 SS=E | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 73 residents. Based on observation and interview, the facility failed to ensure a working call system for 2 resident rooms, and 3 resident bathrooms, affecting 6 residents (#49, #61, #41, #13,#54, #29) on 1 of 2 resident hallways for one of four days on site of the survey.<br><br>Findings included:<br>On 10/23/12 at 10:15 AM, during stage one review of the working condition of resident call lights, the following call lights were found not to sound or light above the resident rooms or at the panel located at the nurses' station.<br><br>Observation revealed two resident rooms and bathrooms which involved residents #40, #41, #54, #61, call lights which failed to light above the hall doorway and failed to light at the panel when pressed.<br><br>Observation revealed an additional bathroom for residents #13, #29, had a call light that failed to | F 463 | | |

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| F 463 | Continued From page 16<br>sound, failed to light above the residents' doorway, and failed to light at the control panel board when pressed.<br><br>On 10/23/12 at 12:15 P.M. maintenance staff W said that all the call lights should be work now. He/she said on 10/19/12 he/she did repaired some things and must have accidentally cut the wires to those call lights. He/she provided a sheet dated 9/10/12 through 10/16/12 which addressed the working status of the resident call lights as he/she randomly checked them each month. Follow-up random checks of the facility call lights on 10/24/12 and 10/25/12, revealed functioned properly.<br><br>The facility failed to ensure working call lights which involved 6 residents in 2 resident rooms and 3 resident bathrooms on 1 of 2 resident hallways in the facility. | F 463 | | |